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What Women Want from Their Health Care Providers about Pregnancy Options Counseling: A Qualitative Study

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A B S T R A C T

Objectives: Unintended pregnancy is common in the United States, yet scant research has evaluated women's preferences on pregnancy options counseling. This study explores pregnant women's preferences for pregnancy options counseling from health care providers.
Methods: We conducted semistructured interviews with pregnant women at a prenatal clinic and an abortion clinic. We asked women about recent discussions—or lack thereof—about pregnancy options (parenting, adoption, and abortion) with a clinician, and what they would want their provider to discuss about pregnancy options. We analyzed transcripts using modified grounded theory.
Findings: We interviewed 10 women in prenatal care and 18 women seeking abortion. In both settings, most said clinicians should discuss pregnancy options with pregnant women and 1) respect patient autonomy, 2) avoid assumptions about a woman's desired pregnancy outcome, and 3) consider the patient—including her health and fertility intentions—beyond her pregnancy. Participants wanted their doctors to assess a pregnancy's individual circumstances to determine the appropriateness of options counseling. A few participants, including women who did and did not receive options counseling, reported they personally preferred not to receive such counseling. Explaining this preference, they cited preservation of privacy, having already made a decision for the pregnancy, or just not wanting to discuss abortion. Regarding best practices for providing options counseling, participants said it should be done in a routine manner, with discretion, and early in pregnancy.
Conclusions: Pregnant women seeking both prenatal and abortion care broadly support options counseling.
Implications: Discussion of pregnancy options, including abortion, provides patient-centered care and supports women's preferences.

Several professional organizations have guidelines stating physicians should provide unbiased pregnancy options counseling to pregnant women so they receive accurate information about parenting, adoption, and abortion and can access appropriate care (American College of Obstetricians and Gynecologists, 2007; American Academy of Family Physicians, 2016; Hornberger, 2017; Snyder, 2012). Some additionally state that physicians who object to options counseling should refer patients to another provider (American College of Obstetricians and Gynecologists, 2007; American Academy of Family Physicians, 2016; Snyder, 2012). Despite these guidelines, some physicians do not feel obligated to discuss procedures they feel are immoral, such as abortion. In one survey, 14% of physicians felt it is ethically permissible to withhold information about safe, legal medical procedures with which a physician disagrees, although there are no data on the prevalence of the practice of withholding such information (Curlin, Lawrence, Chin, & Lantos, 2007).

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The discrepancy between professional organizations' guidelines and physicians' desires to exercise their personal beliefs leaves out a central contributor to the options conversation: the woman herself. In overlooking women's preferences, the discussion about and practice of options counseling risks failing to meet patients' needs. One study on women's discussions about their abortion decision with their regular gynecologic care provider suggests that some women may not find significant benefit from such a discussion, whereas other women may have concerns about seeking such counseling (Chor, Tusken, Lyman, & Gilliam, 2016). The Institute of Medicine (2001) defines patient-centered care as "care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions." Experts have investigated best practices for patient-centered counseling for contraception and early pregnancy failure (Dehlendorf, Levy, Kelley, Grumbach, & Steinauer, 2013; Wallace, Goodman, Freedman, Dalton, & Harris, 2010), but little work has evaluated what women want in terms of pregnancy options counseling. To provide patient-centered reproductive health care, providers must assess pregnant women's preferences, needs, and values regarding pregnancy options counseling.

Through semistructured interviews, we explored whether pregnant women with unintended pregnancies want options counseling from their doctors and, when they do want such counseling, their preferences for its delivery and content.

Materials and Methods

Participant Recruitment

Between October 2015 and May 2016, we conducted semistructured interviews with pregnant women 19 years or older in Nebraska. The age of consent in the state is 19 years. We recruited women from a prenatal clinic and an abortion clinic. We selected the two sites to capture different pregnancy outcomes—birth and abortion—because we anticipated the participant's intended pregnancy outcome might influence women's options counseling preferences. The abortion clinic, one of three in the state, serves a racially and socioeconomically diverse population, and—like the national population of women seeking abortion—women with lower incomes are overrepresented (Jerman, Jones, & Onda, 2016). The prenatal clinic serves a population similar to women at the abortion clinic regarding racial and socioeconomic diversity, yielding roughly similar demographics across recruitment sites.

We recruited women from the prenatal clinic who may have benefited from options counseling by asking: "Were you planning or hoping or trying to get pregnant when you did?" Those who answered 'no' were eligible for the study. Women at the abortion clinic were eligible if they had not planned to be pregnant and had met with a clinician before their abortion appointment. For both sites, we excluded women more than 22 weeks pregnant (the gestational age beyond which the state prohibits abortions) and women with pregnancies affected by fetal anomalies (we felt these women would have different options counseling preferences). The institutional review boards at the University of Nebraska Medical Center and the University of California, San Francisco, approved this study.

Clinic staff gave prospective participants a flier describing the study. If a woman expressed interest in participating, clinic staff gave the woman's first name and phone number to the first author, who contacted the prospective participant by phone to screen for eligibility and, if eligible and interested, obtained verbal informed consent. The first author then either conducted the interview or scheduled a later interview. Owing to low recruitment, we later modified the study protocol so clinic staff referred interested women directly to an onsite study team member who completed screening, obtained informed consent, and conducted the interview. The first author reviewed the recording of interviews conducted on-site within 1 week of the interview. Recruitment continued independently at each site until the first author judged that the interviews had reached saturation, which was defined as the absence of novel interview themes (Charmaz, 2006).

Interviews

Interviews included questions about participants' recent discussions—or lack thereof—about pregnancy options with a doctor, and their preferences regarding options counseling. When asking about pregnancy options counseling, interviewers used the phrase "parenting, adoption, and abortion" to avoid ambiguity about the definition of "pregnancy options." We also collected demographic information. Participants received a $40 gift card to compensate them for their time. We recorded all interviews and transcribed them verbatim.

Analysis

After completing data collection, the first and senior authors analyzed the transcripts using modified grounded theory, a systematic approach that identifies recurring ideas, elements, and concepts (Charmaz, 2006). Individual codes are iteratively reviewed and reassessed, sometimes grouping codes together and sometimes splitting codes into more precise subcodes, to identify patterns and themes related to the research question. As an inductive approach, it does not start from hypotheses or assumptions about patterns in the data and is appropriate for exploratory studies. Applying modified grounded theory, the first author, in consultation with the senior author, coded five interviews and designed the codebook to analyze participant preferences, wants, and needs regarding options counseling. Once we agreed on the codebook, the first author then coded all transcripts using Dedoose version 6.2.7 (SocioCultural Research Consultants, LLC; Los Angeles, CA) and discussed any emergent code ambiguities or redundancies with the senior author. We considered the codebook complete when no new codes emerged during coding; coding was complete when the finalized codebook was applied to all transcripts. In the results presented herein, we refer to the general prevalence of identified patterns to signal the extent our data fully captures the contours of those patterns; references to frequency of specific patterns should not be interpreted as indicative of generalizable frequencies, because our sample is not representative.

Results

Sample Characteristics

We interviewed 10 women in prenatal care and 18 women seeking abortion before reaching saturation and ceasing recruitment. We interviewed all women seeking abortion and four of the women in prenatal care in person; six women recruited from prenatal care were interviewed by phone. Interviews ranged from just over 5 minutes (owing to time